

Figure SC810.F10. Instructions for completing Form CA-2

**CPMS INSTRUCTIONS FOR COMPLETING FORM CA-2,
NOTICE OF OCCUPATIONAL DISEASE AND CLAIM FOR
COMPENSATION**

The employee or the employee's representative fills out Items 1 through 18 as follows:

- Item 1. Employee's last name, first name, middle name (enter NMN if no middle name.)
- Item 2. Employee's social security number.
- Item 3. Employee's date of birth (month, day, year) - NOT TODAY'S DATE OR CURRENT YEAR.
- Item 4. Employee's gender.
- Item 5. Employee's home telephone number with area code; if no home phone enter "NONE."
- Item 6. Grade and pay as of date of last exposure.
- Item 7. Employee's complete home mailing address, including ZIP code.
- Item 8. Employee marks the appropriate boxes - numbers are not required. If no dependents, enter "NONE."
- Item 9. Employee's job title, employees pay plan, and the four numbers of the occupational series as listed on the SF 50.
- Item 10. Work location where disease or illness developed. Show complete address including 9-digit ZIP code if location is not the same as Item 8.
- Item 11. The date that the employee first became aware of the disease or illness. (This may or may not be the same date that he or she realized that it was caused or aggravated by his or her employment.)
- Item 12. The date that employee realized the disease or illness was caused or aggravated by employment.
- Item 13. The employee should be very specific.
- Item 14. Description of the condition claimed to be work-related.
- Item 15. If an entry is required, give a specific reason.
- Item 16. If separate narrative on the disease is not submitted with this form, explain reason for delay.

Item 17. If required medical forms are not attached, explain reason for delay.

Item 18. Be sure the normal signature is used. This is the actual date the completed Form CA-2 is submitted to the supervisor.

NOTE: Be sure to instruct employee to furnish all information as required in the instructions. Failure to do so might delay adjudication of the claim.

The supervisor fills out Items 19 through 34.

Item 19. Enter complete address of the servicing CPO/HRO authorized to forward the Form CA-2 to the OWCP. This address may or may not be the same as that in Item 10. Use the appropriate numeric and alpha chargeback code.

Item 20. Enter the street address and 9-digit ZIP code of the establishment where the employee actually works.

Item 21. If the employee has a fixed schedule, enter beginning and ending times. If intermittent, enter "INTERMITTENT."

Item 22. If the employee has a fixed schedule, indicate the scheduled workdays. If the employee has a rotating schedule, enter "ROTATING."

Item 23. Enter the name and address of the physician who first provided care for the claimed work-related illness/disease.

Item 24. Obtain this data from the medical reports submitted by the employee, if available. If reports are not available, enter "UNKNOWN."

Item 25. Refer to the most current medical reports. Do not use verbal information received from the employee. If no medical reports are available, enter "NO REPORT AVAILABLE."

Item 26. Enter specific date you were first notified of physical condition being related to employment.

Item 27. If no disability has been caused, enter "HAS NOT STOPPED."

Item 28.

If the employee did not stop work, enter "NA."

- If a period of disability was caused by the claimed illness/disease, enter the specific date and time the employee stopped work.

- If the employee was disabled due to the claimed illness/disease and entered into a LWOP status commencing after the exhaustion of the employee's sick and annual leave, enter the specific date and time the LWOP status started.

- If the employee was disabled due to the claimed illness/disease and used sick or annual leave throughout the period of disability, enter "NA, USED SICK OR ANNUAL LEAVE."

- If employee has been separated and will not return to work, give date of separation.

Item 29. Based on the condition identified as the cause of the illness/disease in the employee's statement, determine if a specific answer is possible.

Item 30. If employee did not stop work, enter "NA."

- If employee did stop work due to the claimed illness/disease:

- (1) Enter the date and hour the employee returned to work following the disability period; or

- (2) Enter "HAS NOT RETURNED" if disability continues beyond the date the Form CA-2 is submitted.

Item 31. Complete this item only if the employee returned to work following a period of disability and the work assignment has changed. If so, describe the new duties and indicate if the assignment is a light-duty assignment. If the work assignment has been changed to accommodate the claimed illness/disease without a period of disability, so indicate.

Item 32. Check appropriate block.

Item 33. Self-explanatory.

Item 34. Self-explanatory.

Item 35. If you take exception to any information furnished by the employee in Items 1 through 18, identify the items and explain the reasons. Use an attachment if necessary. If not, enter "NA."

NOTE: 1. Be sure to include statement commenting on employee's narrative statement as required by instructions.

NOTE: 2. Complete the Receipt of Illness/disease portion and promptly give it to the employee.